**SPEAKER EXPENSE CLAIM FORM**

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| **SECTION A** | | |
| **Complete Section A**  Always attach receipts or other supporting documents. Ensure that the Payee’s Name and Address are clearly completed. If the Claimant’s Name and Address differ from those of the Payee, please provide both. Submit the completed form, along with the receipts, to [charline.mere@bms.com](mailto:charline.mere@bms.com)  **PLEASE NOTE:** ISCB is a non-profit organization and, as a principle, does not pay honoraria. As a guideline, travel expenses are typically reimbursed at the rate of a second-class rail fare or an economy-class airline ticket. | | |
| **Date of expense:** | **You can claim in EUR Detailed description of expense:** | **Total EUR** |
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| **TOTAL REIMBURSEMENT DUE** | | **EUR** |
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| **Are you a Health Care Professional (HCP)?:** YES NO | | |
| **Name Signed: Date:** | | |
| **Company: Address:** | | |
| **Country: Tel: Email:** | | |
| ***If you wish to receive payment by bank transfer, please provide your bank details:*** | | |
| **Sort Code:**   **Bank Account:** | | |
| **SWIFT/BIC: IBAN:** | | |
| After completing the form, please forward it along with the attached receipts to [charline.mere@bms.com](mailto:charline.mere@bms.com)  **SECTION B** *TO BE COMPLETED AND AUTHORISED BY STAT BLOC TREASURER* | | |
| Name (BLOCK CAPITALS): ……………………………………… Signature: ………………………………………………  Approved for payment: YES NO Date: …………………………………………………….. | | |